NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

Dear Applicant / Referral Source:

Thank you for your interest in the Niagara County Department of Mental Health & Substance Services Adult Single Point of Access. Following this page you will find information on the ASPOA description of services, application guide, criteria for referral, and application for services.

If you are requesting services for **yourself and completing the application**, please do your best to fill in all sections. If you are not sure about the diagnosis section, you may leave this blank, but be sure on the authorization form to write in your mental health provider's name and/or agency you attend, or have attended in the past, so we may request this information.

For referral sources, please complete all applicable sections of the application (see application guide).

- Please complete **ALL appropriate SECTIONS** of this application:
- **Please attach all necessary supporting documentation to the application**

Please mail, fax or email (secure / encrypted) the completed application and supporting documentation as noted above to the following:

By Mail:	SPOA Program Niagara County Dept. of Mental Health & Substance Abuse Services 5467 Upper Mountain Rd. Suite 200, Lockport, NY 14094
By Fax:	(716) 439-7418
By Email:	NCDMH@niagaracounty.com

Should you have questions, concerns and/or would like more information, please contact us at (716) 439-7527 or 439-7410. We are happy to assist you.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION
Adult Single Point of Access (ASPOA) Description of Services

The Adult Single Point of Access (SPOA) serves Seriously and Persistently Mentally Ill (SPMI) consumers who are Niagara County residents and may be in need of housing or care management services. The Adult SPOA provides a single entry point for consumers to be able to enter the system more seamlessly, be served more appropriately, and gain more from the experience of being served by one or more of Niagara County's agencies. All stakeholders (consumers, Niagara County Department of Mental Health, New York State Office of Mental Health, and contract agencies) have the opportunity to view themselves as partners in a system that works together to help them meet their individual needs.

The Single Point of Access (SPOA) for Adults in Niagara County is a result of the "New Initiatives Project" assigned by the New York State Office of Mental Health for County implementation. SPOA core values are:

- Incorporate NYS OMH Best Practices to improve quality and effectiveness of services.
- Assure access to services for individuals with the greatest need.
- Promote a responsible, comprehensive, and coordinated service delivery system with consumers, service providers, consumer family members, and the Niagara County Mental Health Department. Facilitate movement among the appropriate levels of service.
- Involve consumers in aspects of service planning, evaluation, and delivery and use peer support when possible.
- Ensure consumer choice

CARE MANAGEMENT SERVICES:

Comprehensive care management; care coordination; health promotion; comprehensive transitional care, including appropriate follow up from inpatient to other settings; patient and family support; referral to community and social support services; and use of health information technology to link services. *Care management is available to individuals with and without Medicaid coverage.*

ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM

An evidenced-based practice that offers treatment, rehabilitation, and support services, using a person-centered, and recovery- based approach, to individuals. ACT services - assertive outreach, mental health treatment, health, vocational, integrated dual disorder treatment, family education, wellness skills, community linkages, and peer support - are provided to individuals by a mobile, multi-disciplinary team in community settings. The goal of ACT services is to assist individuals to achieve their personally meaningful goals and life roles. ACT services are provided by Spectrum Health & Human Services

RESIDENTIAL / HOUSING PROVIDERS & SERVICE LEVELS:

- **Community Missions Inc: 24 hour Supervised Treatment Community Residence** –A 10 or 12 bed structured home-like environment for clients requiring extra support or extra skills training. Some single bedrooms are available.

- **Community Missions Inc: Supportive Residential Apartment Treatment Program** - An on-site or off-site apartment environment for clients who have basic skills. Some single bedrooms and single apartments are available.

- **Community Missions Inc., Recovery Options Made Easy Inc., Living Opportunities of DePaul and Transitional Services Inc. (TSI): Supportive Housing Program** –Affordable, independent, subsidized housing that is furnished and appropriately equipped. Staff available for basic support and guidance relating to landlord relations, linkage for services, and coordination of mental health care.

- **Community Services Packet Boat Landing Single Room Occupancy (SRO)** - ***Income and occupancy requirements apply.*** Each one-bedroom apartment features: a fully-equipped kitchen with a range/refrigerator and microwave; a wall-mounted TV including basic cable service; in-unit storage. Heat, air conditioning, hot water and electric are included in the rent and community laundry facilities are available at no cost. Tenants will have access to a computer lab with Wi-Fi access throughout the building, community room and lounges. The building is 100 % smoke free. There will be designated smoking areas provided outdoors. A security deposit, equal to one month's rent, is required at the lease signing and the applicant ***must meet the eligibility requirements with the Low Income Housing Tax Credit Program***.

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OTHER SERVICES AVAILABLE THAT DO NOT REQUIRE APPLICATION THROUGH SPOA:

Niagara County Dept of MH: Hospital Diversion: The Hospital Diversion services are provided by a Licensed Social Worker who will provide linkages to necessary services for individuals. Adults can utilize the Social Worker for supportive visits as well as linkages to community resources. While the individual awaits contact with needed resources, The Social Worker will maintain contacts with the individual to provide counseling, and help maintain mental and emotional stability. The Social Worker aims to assist the individual to safely remain in the community and avoid hospitalization. The Social Worker is available in the evenings to provide individuals with additional after-hour support, treatment linkages, and referrals.

Niagara County Dept of MH: Crisis Services Coordination: Crisis Services Coordination (CSC) is provided by a Licensed Social Worker who provides Short-Term Case Management for individuals in need of support, assessment, referral or linkage to long term services. CSC is available to individuals residing in Niagara County who experience mental health issues and co-occurring concerns such as substance abuse and/or developmental disabilities. Referrals can be made through Crisis Services.

Niagara County Dept of MH: Forensic Case Management: The Forensic Case Manager provides mental health services for individuals who have been incarcerated and are being released from the Niagara County Jail or other facility, or enrolled in parole or probation. Services, including case management and referrals to needed supports, such as housing and mental health counseling, are provided by a Licensed Social Worker.

Partnership for Healthy Aging Program: The Partnership for Healthy Aging in Niagara County is a unique collaboration between the Niagara County Department of Mental Health & Substance Abuse Services and the Niagara County Office for the Aging. The goal of this program is to assist individuals in Niagara County age 55 and older to remain safely in the community and also to help them to flourish by remaining connected with medical, behavioral health and non-medical supports in the community.

Dale Association Peer Specialist Program: provides individual, issue-specific and systems advocacy to SPMI adults ages 18 and older. The Peer Specialist is a former recipient of mental health services and has received specific training to assist peers in building the skills necessary to live independently in the community and to link with other appropriate services in the community.

Community Missions Inc. Parole Reentry Program: This program is part of the Niagara County Reentry Taskforce and serves incarcerated persons returning to the community.

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APPLICATION GUIDE

- **FOR ADULT SPOA, Pages 1 – 5 must be fully completed and submitted for review.**
  - **Page 1 - 3: ASPOA Application Information**
  - **Page 4 – 5: ASPOA Consent to Release & Obtain Information Form** (must be completed and included with submitted application packet).
  - **Page 6 - 7: ASPOA Family / Collateral Contact Consent Form (optional, but encouraged)**
- **Also required to complete application:** Supporting documentation of CURRENT/ MOST RECENT mental health diagnosis. Documentation can include an initial psychiatric assessment, psychiatric progress note, treatment plan, discharge summary, etc. listing referred individual's current / most recent diagnosis *given or signed off by a psychiatrist / doctor, psychiatric nurse practitioner, Ph.D., LCSW-R or LCSW.*

The following attachments only need to be completed if requesting consideration for these services:

- **Attachment A: Assertive Community Treatment (ACT) Team** Eligibility Criteria *(required only if **ACT services are being requested**)*

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Client's Name:	**Date of Birth**:	**Age**:

ELIGIBILITY DETERMINATION

☐ **In order to be eligible for services through the ASPOA Program, applicants must meet ALL of the following criteria: Age 18 and older**

☐ **Be willing to participate in services**

Meets criteria for *Serious and Persistent Mental Illness (SPMI) as defined below

* (Must meet Criterion 1 **plus** 2 or 3 or 4)

☐ 1.) **Currently meets criteria for a DSM Psychiatric Diagnosis** (using the most current manual) other than alcohol / drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD–CM psychiatric categories and codes that do not have an equivalent in the DSM are also included mental illness diagnoses.

AND

☐ 2.) **SSI or SSDI enrollment due to a designated mental illness**

OR

☐ 3.) **Experienced at least 2 of the following 4** functional limitations due to mental illness over past 12 months on a continuous or intermittent basis

☐ Self-care ☐ Activities of daily living ☐ Social functioning ☐ Deficits in concentration, persistence or pace resulting in failure to complete tasks in timely manner

OR

☐ 4.) **Reliance on psychiatric treatment, rehabilitation and supports**: A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by psychotropic medication or psychiatric rehabilitation and supports (e.g. highly structured and supportive settings such as Congregate or Apartment Treatment Programs).

PSYCHIATRIC DIAGNOSIS DESCRIPTION *(include ICD-10 codes when possible)*

Name & credentials of professional who made (or signed off on) diagnosis *(must be a doctor, Ph.D., psychiatric nurse practitioner, LCSW / LCSW-R)*: _____

Date of Diagnosis *(Please be sure to write in **most recent** date of assessed diagnosis only)* _____

CLIENT IS ALSO IDENTIFIED AS HAVING *(please check all that apply)*:

☐ **Chronic conditions, which include** *(check all that apply)*:

☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ BMI > 25 ☐ Substance Use Disorder

☐ Other chronic condition (*specify*):

☐ HIV / AIDS (*include separate consent specifying this information can be shared*)

☐ Risk of developing another chronic condition

ASPOA SERVICE REQUESTED

☐ **Care Management** *if you have a preference in provider, please specify:*

☐ **Assertive Community Treatment (ACT) Team** **must complete / meet eligibility criteria sheet – Attachment A*

Residential - ☐ **Community Missions Inc. 24 Hr. Supervised Community Residence (CR)**

☐ **Community Missions Inc. Supportive Residential Apartment Treatment Program**

☐ **Supportive Housing** if you have a preference in provider, please specify:

☐ **DePaul Community Services Packet Boat Landing Single Room Occupancy (SRO)**

OTHER AVAILABLE SERVICES REQUESTED

☐ **NCDMH Hospital Diversion**	☐ **Dale Association Peer Specialist Services**
☐ **NCDMH Crisis Services Coordination / Forensic Case Mgmt**	☐ **Partnership for Healthy Aging Services**
☐ **Community Missions Inc. Parole Reentry Services**	

CLIENT INFORMATION

Social Security #	**Gender** ☐ Male ☐ Female ☐ Other, Specify:		
Home Street Address		**Town**	**Zip**
Mailing Address *if different*		**Town**	**Zip**
Home Phone #	**Cell Phone #**	**Work / Other Phone #**	

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Client Name:

HEALTH INSURANCE / BENEFITS

Health Insurance: ☐ Yes ☐ No ☐ Unknown	**Application Pending for**: ☐ Medicaid ☐ Medicare ☐ Managed Care ☐ Other ***specify***: ***Specify pending date of approval***:
If Medicaid – provide #	**Medicaid Active?** ☐ Yes ☐ No **If no, eligible?** ☐ Yes ☐ Unknown
Other Insurance Type: **Policy #**	**Policy Holder:**

Current benefits received ☐ None ☐ Unknown ☐ SSI ☐ SSD ☐ Survivor's ☐ Veteran's ☐ Earned Income (work) ☐ Unemployment ☐ Public Assistance ☐ Child Support ☐ Resources/Assets (savings bonds, savings account, trust fund, etc) ☐ Other *(specify)*

DESCRIPTION OF INDIVIDUAL

Ethnicity *(check all that apply)* ☐ Unknown ☐ White/Non-Hispanic ☐ African American ☐ Latino ☐ Hispanic ☐ Asian ☐ Native American/Alaskan ☐ Other *(specify):*

Brief physical description *Please provide approximate height, weight, hair / eye color, identifying features – i.e. piercings, tattoos, etc.*

SPECIAL NEEDS & PREFERENCES

Are services required in a language other than English? ☐ No ☐ Yes *If yes, specify language*:

Other physical, medical, visual, hearing, cultural/religious, writing, reading, developmental disability) *(specify):*

LIVING SITUATION

Marital Status ☐ Single never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown ☐ Other *(specify)*

☐ Alone	☐ Unrelated member's home	☐ Homeless/Streets
☐ With Child / Children (#_____)	☐ Facility Name: _____	☐ Jail/Correctional Facility *(facility name):* _____
☐ With parent(s)	*(specify type)* _____	☐ Emergency / runaway shelter *(facility name):* _____
☐ Other relative's home		

Living environment safe? ☐ Unknown ☐ No ☐ Yes **Animals in the home?** ☐ Unknown ☐ No ☐ Yes, ***specify type***:
Weapons in the home? ☐ Unknown ☐ No ☐ Yes, ***specify type***:

SERVICE / TREATMENT HISTORY

Service / Treatment	Provider(s) Name	Notes	Timeframe				
			Current	Past 30 days	Past Year	>1 year ago	No History
Primary Care		*Last Appt:* _____	☐	☐	☐	☐	☐
Mental Health Outpatient		*Next Appt:* _____	☐	☐	☐	☐	☐
Psychiatric Inpatient		*# of times:* _____	☐	☐	☐	☐	☐
Psychiatric ER / CPEP		*# of times:* _____	☐	☐	☐	☐	☐
Emergency / Crisis Services		*# of times:* _____	☐	☐	☐	☐	☐
Substance Abuse Outpatient			☐	☐	☐	☐	☐
Substance Abuse Inpatient		*# of times:* _____	☐	☐	☐	☐	☐
Medical Hospitalization		*# of times:* _____	☐	☐	☐	☐	☐
Medical ER (without admit)		*# of times:* _____	☐	☐	☐	☐	☐
Residential			☐	☐	☐	☐	☐
Legal Involvement	*Specify details of charges/ convictions, release date, etc.:*		☐	☐	☐	☐	☐
☐ Probation / ☐ Parole		*Expiration date:* _____	☐	☐	☐	☐	☐
☐ APS / ☐ CPS			☐	☐	☐	☐	☐
Care Mgmt / Health Home			☐	☐	☐	☐	☐
Assisted Outpatient Treatment (AOT)		Voluntary contract Order, *exp. date*	☐	☐	☐	☐	☐
Assertive Community Treatment (ACT) Team			☐	☐	☐	☐	☐
Developmental Disability			☐	☐	☐	☐	☐
Other *(specify):*			☐	☐	☐	☐	☐

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Client Name:

SERVICES INDIVIDUAL *IN NEED OF & NOT* RECEIVING

☐ Individual Therapy	☐ Day Treatment	☐ PROS	☐ Group Therapy
☐ Medication Management	☐ Family Therapy	☐ Couples/Marital Therapy	☐ Alcohol/Substance Abuse Treatment
☐ Primary Medical Care	☐ Health Promotion	☐ Family Support	☐ Peer Support / Mentoring
☐ Literacy Services	☐ Educational	☐ Vocational Training	☐ Employment
☐ Benefits/Entitlements	☐ Housing	☐ Transportation	☐ Crisis Intervention
☐ Daily / Independent Living Skill Development	☐ Social/Recreational/Community Activities		☐ Advocacy
☐ Coordination of services	☐ Comprehensive transitional care, including appropriate follow up from inpatient to other settings		
☐ Other (*please specify*):			

INDIVIDUAL'S RISKS & SAFETY CONCERNS

- ☐ At risk for adverse event *(i.e. death, disability, inpatient admission, mandated preventative services, or out of home placement)*
- ☐ Has inadequate social / family/ housing support or serious disruptions in family relationships
- ☐ Has inadequate connectivity to healthcare system
- ☐ Does not adhere to treatments or has difficulty managing medications
- ☐ Has recently been released from incarceration, placement, detention
- ☐ Has recently been released psychiatric hospitalization
- ☐ Has deficits in daily living: dressing, eating, etc.
- ☐ Has learning or cognition issues

Risk / Concerns	Current	Past Yr	History	Risk / Concerns	Current	Past Yr	History
☐ Suicidal Ideation	☐	☐	☐	☐ Access to weapons	☐	☐	☐
☐ Suicide Attempts	☐	☐	☐	☐ Sexual Inappropriateness	☐	☐	☐
☐ Self-injury	☐	☐	☐	☐ Gang Involved/ Activity	☐	☐	☐
☐ Property Destruction	☐	☐	☐	☐ Homicidal Ideation	☐	☐	☐
☐ Running Away / AWOL	☐	☐	☐	☐ Violence / Aggression	☐	☐	☐
☐ Poor Decision Making	☐	☐	☐	☐ Alcohol / Substance Use	☐	☐	☐
☐ Impulsivity	☐	☐	☐	☐ Cruelty to Animals	☐	☐	☐
☐ Victim of Bullying	☐	☐	☐	☐ Fire Setting / Arson	☐	☐	☐
☐ Victim of Abuse	☐	☐	☐	☐ Other – specify	☐	☐	☐

EXPLAIN ADDITIONAL INFORMATION REGARDING RISK & SAFETY CONCERNS BELOW IF NEEDED

REFERRAL SOURCE INFORMATION

Referral Source Name *(Please Print)*:	**Relationship to individual**
Referral Source Signature:	**Date:**
Agency / Program:	**Phone #:**
Complete Address:	
Email Address:	

OTHER SIGNIFICANT CONTACTS NOT LISTED ABOVE

Name (First, MI, Last)	**Relationship:**
Phone #	**Primary Contact?** ☐ *Yes ☐ No
Street Address	**Emergency Contact?** ☐ *Yes ☐ No
City	**If yes, complete collateral contact consent page*
State, Zip	

Niagara County Department of Mental Health & Substance Abuse Services
Permission to Use & Disclose Confidential Information (2 pages - side 1 of 2)

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and educational records as described below.
2. The person whose information may be used, disclosed or re-disclosed is:

Client Name:	**Date of Birth:**

3. The information that may be used, disclosed or re-disclosed includes health, mental health, alcohol/drug, school /educational records.
4. This information may be disclosed/ re-disclosed **by** *any person or organization that possesses information to be disclosed; the persons or organizations listed in* ***Attachment A****; and the persons or organizations listed in* ***Box 1****.*

Box 1

5. This information may be disclosed or re-disclosed **to** *any person or organization that needs the information to provide service to the person who is the subject of the record, and/or pay for those services, and/or engage in quality assurance and/or other health care operations related to that person, and/or the person or organizations listed in* ***Attachment A****, and/or the persons or organizations listed above in* ***Box 1.***

6. The purpose for which this information may be used, disclosed or re-disclosed include:
   - Evaluation of eligibility to participate in a program supported by the Niagara County Department of Mental Health and Substance Abuse Services;
   - To determine initial and continuing home & community based services (i.e. Mobile Integration Team services, Waiver, Multi-Systemic Therapy, Community Crisis Intervention, family support services, respite, Hospital Diversion, Crisis Service Coordination, Forensic Case Management, Partnership for Healthy Aging, Assertive Community Treatment, Assisted Outpatient Treatment, care management, etc.), residential services, and treatment eligibility, level of service / care, and needs;
   - To make recommendations for appropriate services and treatment;
   - To assign appropriate services offered through or in partnership with, Single Point of Access (SPOA) programs;
   - To plan and coordinate services and treatment, and for service and treatment delivery;
   - To complete utilization review of assigned service(s) and treatment(s);
   - To access data in and/or facilitate a referral/enrollment in a Health Home via the Medicaid Analytic Performance Portal (MAPP) if appropriate;
   - To access data in PSYCKES to determine service eligibility and level of service need;
   - For payment of services and treatment;
   - Health Care Operations such as quality assurance;

   I further understand that:
   - Only this information may be obtained, used, disclosed and re-disclosed as a result of this authorization.
   - I have the right to participate in the SPOA committee discussion regarding the appropriate level of service for my needs when being referred to SPOA.
   - This information is confidential and cannot be legally disclosed without my permission.
   - It is the role of the SPOA committee to oversee the use of home & community based services (i.e. Mobile Integration Team services, Waiver, Multi-Systemic Therapy, Community Crisis Intervention, family support services, respite, Hospital Diversion, Crisis Service Coordination, Forensic Case Management, Partnership for Healthy Aging, Assertive Community Treatment, Assisted Outpatient Treatment, care management, care coordination, etc.) and residential services in Niagara County and to decide what level of service is most appropriate for each client in light of the demands for those services. The committee's decision will be based on information about me.
   - I have a right to inspect and copy my own protected health information to be used, disclosed and/or re-disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. **Periodic Use / Disclosure:** Unless my permission is withdrawn in writing I understand that this consent / authorization **will remain in effect as long as I continue to receive the services covered under this authorization** for the purposes described above as often as necessary to fulfill the purposes identified above.

9. *(ONLY FILL OUT THIS PART IF YOU ARE PLACING LIMITATIONS EXPIRATION OF PERMISSIONS AND/OR LIMITATIONS ON PERMISSIONS), if none, skip this part:*
   a. *This permission expires (check any that apply)*
      On the following date: _____
      Upon the following event: _____
   b. *This permission is limited as follows:*
      Permission only applies to the records for the following time period: _____ to _____
      Other limitation: _____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given. **I hereby affirm and certify I have read the entire foregoing Consent, I understand all of its terms, I agree to be bound by all of its terms, I agree to comply with all of its terms, and I am signing this Consent upon my free will and volition.**

I am the person, or personal representative of the person, whose records will be used, disclosed and/or re-disclosed. I give permission to use, disclose and/or re-disclose my records as described in this document.

_____ _____

Signature of Client or legal Personal Representative — Date

_____ _____

Personal Representative's Name (as applicable / for clients under the age of 18) — Relationship to Person for whom you are signing

List of agencies with which the Niagara County Adult SPOA Program and Committee is permitted to exchange information - Attachment A

This permission to use, disclose and/or re-disclose records applies to the following organizations and people who work at those organizations as appropriate. These organizations work together to deliver services to residents of Niagara County.

• Beacon Center	• New Directions Youth & Family Services, Inc.
• Best Self Behavioral Health • BestSelf Health Home *(includes all associated care management agencies)*	• Niagara County Department of Mental Health & Substance Abuse Services
• BryLin Hospitals, Inc.	• Niagara County Department of Social Services
• Buffalo Federation of Neighborhood Centers (BFNC)	• Niagara County Office for the Aging
• Buffalo Psychiatric Center	• Niagara County Probation Department
• Cattaraugus Rehabilitation Center Community Residence	• Niagara Falls Memorial Medical Center (NFMMC)
• Catholic Charities of WNY	• NFMMC Health Home Care Management
• Catholic Health System	• Northpointe Council, Inc.
• Cazenovia Recovery Systems	• NYS Department of Corrections and Community Supervision (includes Parole)
• Central NY Psychiatric Centers and satellite offices	• NYS Council on Children and Families – Interagency Resolution Unit *(formerly Hard to Place / Serve Committee)*
• Child & Family Services	• OISHEI Healthy Kids and Women & Children's Hospital *(includes all associated care management providers)*
• Children's Health Home of Upstate New York (CHHUNY) *(includes all associated care management providers)*	• Orleans Niagara BOCES
• Children's Health Home of WNY (dba OISHEI Healthy Kids) *(includes all associated care management agencies)*	• Our Lady of Victory (OLV) *formerly Baker Victory Services)*
• Community Health Center of Buffalo (CHCOB) • Community Health Center of Niagara (CHCON)	• Pathways, Inc. Community Residence
• Community Services for Every1	• Person Centered Services
• Community Missions of Niagara Frontier, Inc.	• Pinnacle Community Services (*formerly Family & Children's Services of Niagara)*
• Dale Association	• Prime Care Inc.
• DePaul Community Services • DePaul Properties • Living Opportunities of DePaul	• Prime Care Medical, Inc at the Niagara County Jail • Psychotherapy Associates of Niagara
• Dr. Joshua Russell, MD	• Recovery Center of Niagara
• East Amherst Psychology Group	• Recovery Options Made Easy, Inc. *(formerly Housing Options Made Easy, Inc.)*
• Eastern Niagara Hospital	• Rochester Psychiatric Center (inpatient and children's Community Residence)
• Encompass Health Home *(includes all associated care management agencies)*	• Save the Michaels of the World
• Endeavor Human Services	• School Districts within Niagara County (Barker, Lewiston-Porter, Lockport, Newfane, Niagara Falls, Niagara-Wheatfield, North Tonawanda, Royalton-Hartland, Starpoint, Wilson)
• Empower (formally Niagara Cerebral Palsy)	• Specialty / Treatment Courts within Niagara County
• Erie County Department of Mental Health *(including Single Point of Entry / Access – SPOE / SPOA – Program)*	• Spectrum Health and Human Services
• Erie County Medical Center (ECMC)	• Strong Memorial Hospital
• Evergreen Health Services	• Suburban Psychiatric Associates
• Gateway-Longview	• Transitional Services Inc.
• Glove House Community Residence	• Venture Forthe
• Greater Buffalo United Healthcare Network (GBUHN)	• Villa of Hope
• Harmonia Collaborative Care	• UBMD Physicians Group
• Health Homes of Upstate NY (HHUNY) *(includes all associated care management agencies)*	• WNY Developmental Disabilities Regional Office
• Hillside Family of Agencies (Hillside Children's Center) • Horizon Health Services	• WNYIL - Independent Living Project / Independent Living of Niagara County
• Jewish Family Services	• WNY Office of Mental Health Field Office
• Kaleida Health	• WNY Office of Addiction Services & Supports
• Living Opportunities of DePaul and DePaul Properties	• WNY Children's Psychiatric Center
• Mental Health Association in Niagara County (MHA)	• YWCA of Western NY
• Mental Health Advocates of WNY	•
• Monroe Plan	•

updated 1.2023 mgd

Please ensure this page is included with the completed application. If there is any entity listed above that the referred individual objects to, please cross out that entity and have the individual initial next to it.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
ADULT SINGLE POINT OF ACCESS (ASPOA) APPLICATION

FAMILY / COLLATERAL CONTACT CONSENT FORM (2 pages):

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.)
	Sex Date of Birth
	Facility/Agency Name: **Niagara County Dept of Mental Health & Substance Abuse Services Single Point of Access (SPOA) Program & Agencies Represented on the Committee**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed (PLEASE CHECK AS APPROPRIATE):
☐ Identifying Information ☐ Presence in treatment/services ☐ Information necessary to engage in / coordinate services
☐ Medical Information/Concerns ☐ Lethality/Risk Concerns ☐ Diagnosis/Prognosis/Progress in Treatment/Services
☐ Behavioral/Mental Health Information ☐ Substance use/abuse Information ☐ Legal/Criminal Justice Status
☐ **Other (identify):** _____

Purpose or Need for Information
1. This information is being requested: (PLEASE CHECK ONE)
☐ by the individual or his/her personal representative; or ☐ By Other (please describe) _____
2. The purpose of the disclosure is (PLEASE DESCRIBE): ☐ Continuity of Care ☐ Coordination of Services
☐ Facilitate Referrals/Linkage with Needed Services ☐ **Other (identify):** _____

From/To: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information and To which Disclosure is to be Made *NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*	**To/From:** Name, Address, & Title of Person/Organization/ Facility/Program to Which this Disclosure is to be Made and which is Disclosing Information. *NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
Name: Niagara County Dept. of Mental Health & Substance Abuse Services ASPOA Program which includes represented agencies / service / treatment / residential – housing providers referred to / involved in care . 5467 Upper Mountain Rd. Suite 200, Lockport, NY 14094; Phone: (716) 439-7410; Fax: (716) 439-7418	**Family / Collateral Contact(s):**

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program (s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (**Niagara County Dept. of Mental Health**), shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
ADULT SINGLE POINT OF ACCESS (ASPOA) APPLICATION

Facility/Agency Name: **Niagara County Dept of Mental Health & Substance Abuse Services Single Point of Access (SPOA) Program & Agencies Represented on the Committee**	Patient's Name (Last, First, MI)	ID #

B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.
My authorization will expire:
☑ When I am no longer receiving services from **Niagara County Dept. of Mental Health & Substance Abuse Services SPOA Program and agency assigned that is providing ACT, care management and/or residential services**
☐ Other (specify) _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

Signature of Patient or Personal Representative Date

Patient's Name (Printed)

Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY:
Staff person's name and title
Authorization provided to: Date:

To be Completed by Facility:
Signature of Staff Person Using/Disclosing Information :

Title:

Date Released:

PART 2: REVOCATION of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

_____

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is: _____

_____

_____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)*